R E P O R T R E S U M E S

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MENTAL RETARDATION, A NATIONAL PLAN FOR A NATIONAL PROBLEM. CHART BOOK.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

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GRAPHS ARE USED IN THIS CHART BOOK TO SHOW PROGRESS AND INDICATE NEEDS. SUGGESTED PRIORITY AREAS FOR ACTION ARE--RESEARCH, PREVENTIVE HEALTH MEASURES, CLINICAL AND SOCIAL SERVICES, IMPROVED CARE, A NEW LEGAL AND SOCIAL CONCEPT OF THE RETARDED, SPECIAL EDUCATION, PERSONNEL RECRUITMENT, AND PUBLIC INFORMATION PROGRAMS. THE PREVALENCE OF MENTALLY RETARDED PERSONS, THE SCOPE OF THE PROBLEM, THE TYPES AND CAUSES OF RETARDATION, PERCENTAGE OF MULTIPLY HANDICAPPED PERSONS, AND MEDICAL PROGRESS ARE DISCUSSED. STATISTICS ON INSTITUTIONALIZATION, SPECIAL EDUCATION NEEDS, AND PARENTAL CARE ARE PRESENTED. TEACHER RECRUITMENT NEEDS, REHABILITATION PROGRAMS, AND GROWING PUBLIC AWARENESS ARE DESCRIBED. THIS DOCUMENT WAS PUBLISHED BY SUPERINTENDENT OF DOCUMENTS, U. S. GOVERNMENT PRINTING OFFICE, WASHINGTON, D.C. 20402. $0.45. (JA)

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Mental Retardation

A National Plan for a National Problem

Chart Book

THE PRESIDENT'S PANEL ON MENTAL RETARDATION

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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Chart Book

Mental Retardation

A National Plan for a National Problem

Published for

The President's Panel on Mental Retardation

by the

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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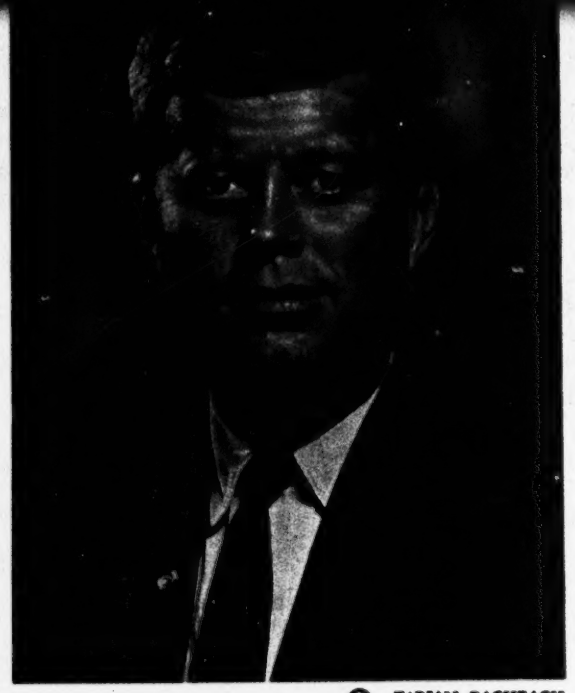

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Excerpts from

THE PRESIDENT'S MESSAGE

CREATING THE PANEL ON MENTAL RETARDATION

"We must undertake a comprehensive and coordinated attack on the problem of mental retardation. The large number of people involved, the great cost to the nation, the striking need, the vast area of the unknown that beckons us to increased research efforts—all demand attention.

"It is for that reason that I am calling together a panel of outstanding physicians, scientists, educators, lawyers, psychologists, social scientists and leaders in this field to prescribe the program of action. I am sure that the talent which has led to progress in other fields of medicine and the physical sciences can enlarge the frontiers of this largely ignored area.

"It shall be the responsibility of this panel to explore the possibilities and pathways to prevent and cure mental retardation. No relevant discipline and no fact that will help achieve this goal is to be neglected.

"The panel will also make a broad study of the scope and dimensions of the various factors that are relevant to mental retardation. These include biological, psychological, educational, vocational, and socio-cultural aspects of the condition and their impact upon each state of development—marriage, pregnancy, delivery, childhood, and adulthood.

"The panel will also appraise the adequacy of existing programs and the possibilities for greater utilization of current knowledge. There are already many devoted workers in this field, trained in diagnosis, treatment, care, education and rehabilitation. The panel should ascertain the gaps in programs and any failure in coordination of activities.

"The panel will review and make recommendations with regard to:

"1. The personnel necessary to develop and apply the new knowledge. The present shortage of personnel is a major problem in our logistics. More physicians, nurses, social workers, educators, psychologists, and other trained workers are needed.

"2. The major areas of concern that offer the most hope, and the means, the techniques and the private and governmental structures necessary to encourage research in these areas.

"3. The present programs of treatment, education and rehabilitation.

"4. The relationships between the Federal Government, the States and private resources in their common efforts to eliminate mental retardation.

"I am asking the panel to report on or before December 31, 1962."

INTRODUCTION

In October 1961, President Kennedy appointed a panel of distinguished scientists, educators, and laymen to prepare a national plan to combat mental retardation—one of the most pernicious and neglected afflictions of mankind.

The panel was asked to review present programs and needs; ascertain gaps in research, diagnosis, treatment, service, and coordination; and to recommend a program of action.

The panel accepted this mandate and, in October 1962, submitted its report to the President. Copies of the full report, entitled "A Proposed Program for National Action To Combat Mental Retardation," may be secured from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402, 65 cents per copy.

The panel's main recommendations in the final report were as follows:

1. *Research* in the causes of retardation and methods of care, rehabilitation, and learning.

2. *Preventive health measures* including (*a*) a greatly strengthened program of maternal and infant care directed first at the centers of population where prematurity and the rate of "damaged" children are high; (*b*) protection against such known hazards to pregnancy as radiation and harmful drugs; and (*c*) extended diagnostic and screening services.

3. *Strengthened educational programs generally and extended and enriched programs of special education* in public and private schools closely coordinated with vocational guidance, vocational rehabilitation, and specific training and preparation for employment; education for the adult mentally retarded, and workshops geared to their needs.

4. *More comprehensive and improved clinical and social services.*

5. *Improved methods and facilities for care,* with emphasis on the home and the development of a wide range of local community facilities.

6. *A new legal, as well as social, concept of the retarded,* including protection of their rights; life guardianship provisions when needed; an enlightened attitude on the part of the law and the courts; and clarification of the theory of responsibility in criminal acts.

7. *Helping overcome the serious problems of manpower* as they affect the entire field of science and every type of service through extended programs of recruiting with fellowships, and increased opportunities for graduate students, and those preparing for the professions to observe and learn at firsthand

about the phenomenon of retardation. Because there will never be a fully adequate supply of personnel in this field and for other cogent reasons, the panel has emphasized the need for more volunteers in health, recreation, and welfare activities, and for a National Service Corps to stimulate voluntary service.

8. *Programs of education and information to increase public awareness* of the problem of mental retardation.

In short in addition to a strong emphasis on research and prevention, the panel has proposed:

a. Comprehensive and improved services, including extended educational and vocational opportunities.

b. Well-coordinated services available to all retarded persons.

c. Community centered, rather than isolated, services, which would be close to teaching and research facilities.

The ultimate goal is prevention of mental retardation, but many steps must be taken by many people and organizations, by the State and Federal Governments, and particularly by private citizens, before that can be realized. The recommendations contained herein indicate some of the things needed to spur an examination into the causes of mental retardation and improve the care and education of all mentally retarded people.

Research, training, protection, education, personnel, parent counseling, rehabilitation, public information, are all means to these ends. The same opportunity for social development that is the birthright of every American must be provided for all mentally retarded children and adults.

While the charts that follow show that we have made progress in the past 10 years they also indicate that we must work intensively to fill the obvious gaps in current knowledge and services.

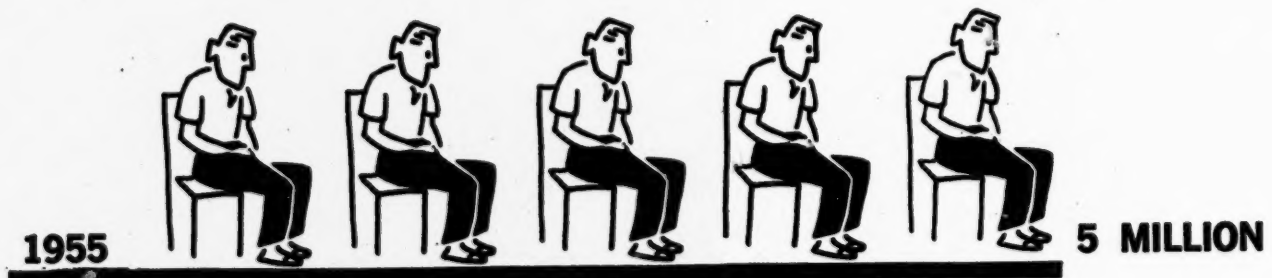
August 1963

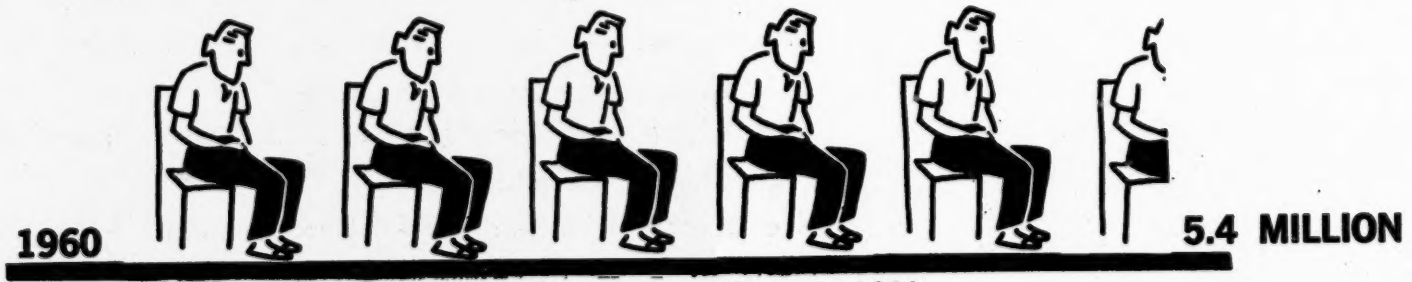
Mental retardation is a condition, characterized by the faulty development of intelligence, which impairs an individual's ability to learn and to adapt to the demands of society.

Information on mental retardation is incomplete, and no adequate means of gathering full statistics have yet been devised. However, using Intelligence Quotient as one measure, experience shows that most people with I.Q.'s below 70 have significant difficulties adjusting adequately to their environment. It is estimated that about 3% of the population would score below this level. Based on 1962 population estimates, about 5.4 million persons would be affected.

Unless there are major advances in methods of prevention, there will probably be one million more mentally retarded by 1970.

THE NUMBERS OF MENTALLY RETARDED ARE INCREASING





At this time, 126,000 infants are born annually who are, or will become, mentally retarded.

Approximately 4,200 (0.1 percent of all births) will be retarded so severely that even as adults they will be unable to care for their own needs of daily living.

About 12,600 (0.3 percent of all births) will remain below the seven-year intellectual level.

The remaining 110,000 (2.6 percent of all births) are those with mild retardation and represent those who can, with special training and assistance, acquire limited job skills and achieve a high measure of independence.

126,000 INFANTS ARE BORN EACH YEAR WHO WILL BE MENTALLY RETARDED

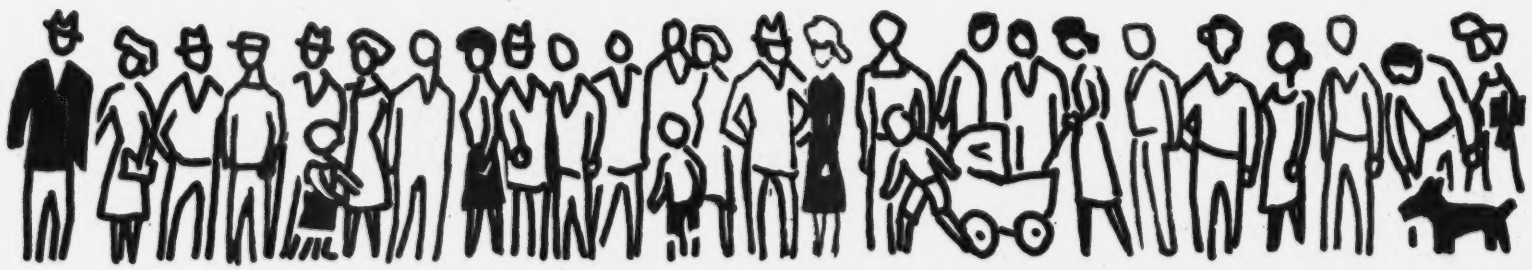
The scope of the problem and its effect is apparent in the large numbers of people affected by this condition. Mental retardation strikes those least able to protect themselves—children. Thus, mental retardation is a serious personal matter to at least one out of every nine people.

Because of changing patterns in the American way of life, many problems of the mentally retarded will become more acute in the future:

- Families are growing larger and in fewer instances will a retarded child be an only child. Parents will have less time and resources to devote to a retarded child.
- Changes in family living will continue. More families move, more live in metropolitan areas. Relatives are no longer readily available to help. More of the burden for caring for the children is being placed on the mother.
- More mothers of young children are in the labor force. Substitute care for the retarded child is more difficult to obtain.

MENTAL RETARDATION TOUCHES MANY PEOPLE

5.4 MILLION PEOPLE ARE MENTALLY RETARDED



THEY AND THEIR FAMILIES ADD UP TO 15 TO 20 MILLION PEOPLE
OR ABOUT 10% OF THE POPULATION

The ratio of mental retardation to the total population persists despite the advances in medical science.

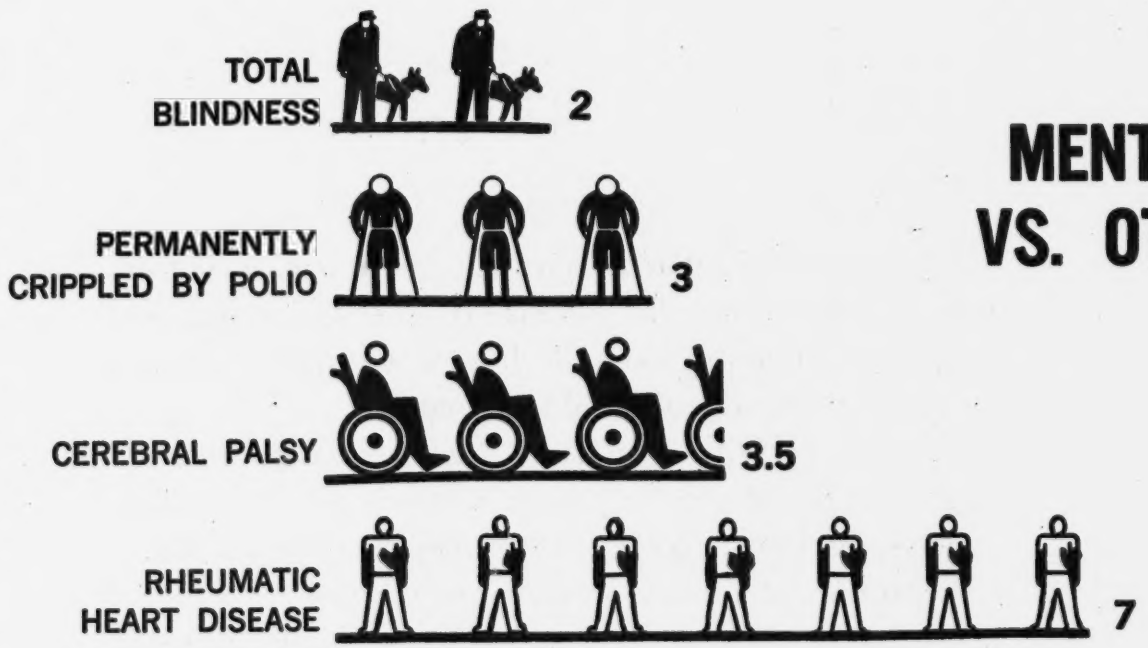
On the other hand, such diseases as whooping cough, diphtheria and scarlet fever have been almost eliminated.

Tuberculosis has been reduced 30 percent in five years. Polio has been dramatically reduced.

Recent studies show a diminishing death rate and an increased life span for the mentally retarded both in and out of institutions. This adds materially to the number of mentally retarded, particularly in the upper age brackets.

MENTAL RETARDATION VS. OTHER CONDITIONS

RATES PER 1,000 PEOPLE



The degree of retardation varies greatly among individuals. It ranges from the profoundly retarded person, who must have protective care for life, to the mildly affected who can achieve a measure of independence.

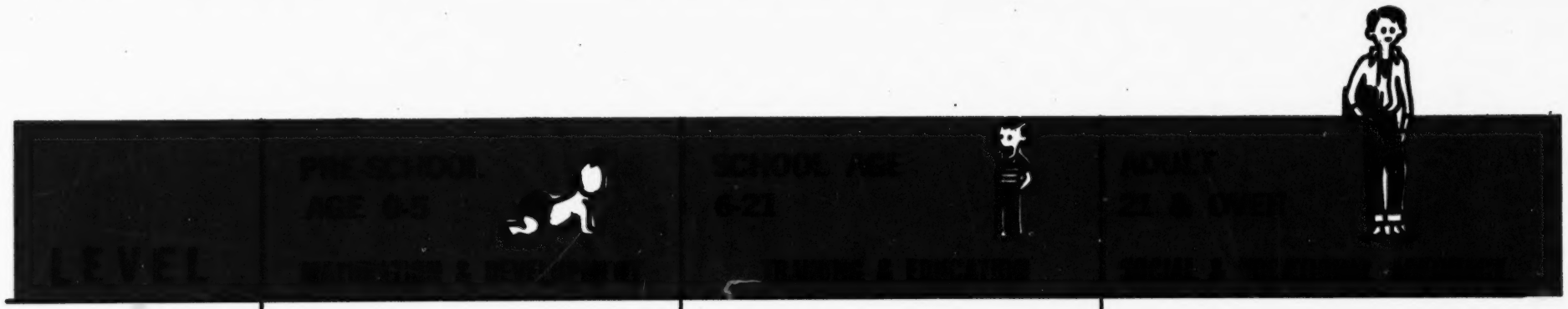
There is no fully satisfactory way of characterizing the degrees of retardation. At present, virtually all classification systems rely heavily on Intelligence Quotient as an index.

Regardless of the classification system used, I.Q. should not be the only factor in determining mental retardation. Other factors which should be considered are social *adaptability and emotional control.*

The developmental characteristics, potential for education and training, and social and vocational adequacy, according to the classification which uses four levels of retardation, are summarized on the opposite page.

In addition to these four levels, another classification, used for educational purposes, is as follows:

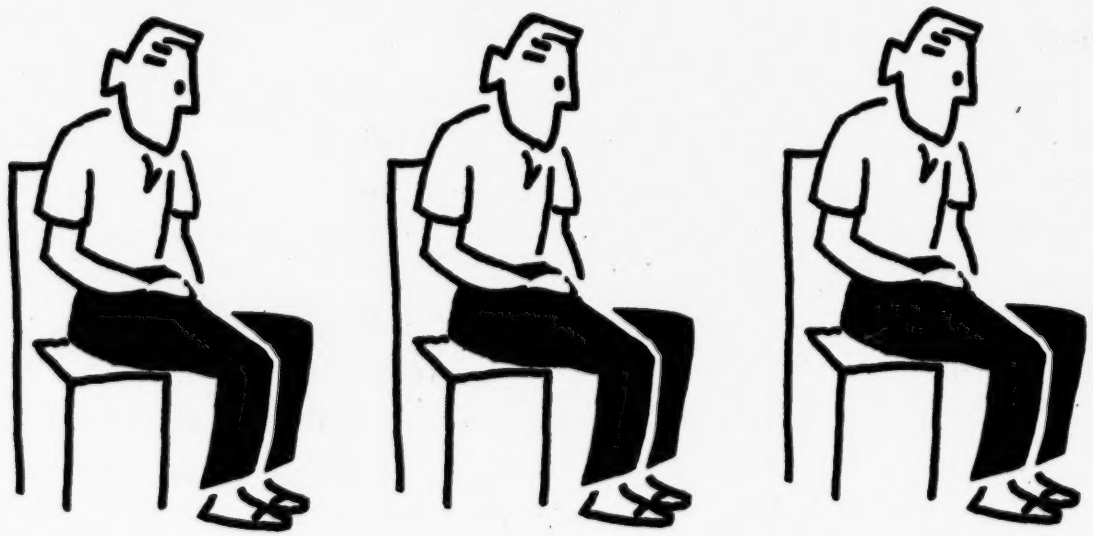
LEVEL	INTELLIGENCE QUOTIENT
—Trainable	About 25–50
—Educable	About 50–75



LEVEL	PRE-SCHOOL AGE 0-5 — MATURATION & DEVELOPMENT	SCHOOL AGE 6-21 — TRAINING & EDUCATION	ADULT 21 & OVER — SOCIAL & VOCATIONAL ADEQUACY
PROFOUND	Gross retardation; minimal capacity for functioning in sensorimotor areas; needs nursing care.	Obvious delays in all areas of development; shows basic emotional responses; may respond to skillful training in use of legs, hands and jaws; needs close supervision.	May walk, need nursing care, have primitive speech; usually benefits from regular physical activity; incapable of self maintenance.
SEVERE	Marked delay in motor development; little or no communication skill; may respond to training in elementary self-help, e.g., self-feeding.	Usually walks barring specific disability; has some understanding of speech and some response; can profit from systematic habit training.	Can conform to daily routines and repetitive activities; needs continuing direction and supervision in protective environment.
MODERATE	Noticeable delays in motor development, especially in speech; responds to training in various self-help activities.	Can learn simple communication, elementary health and safety habits, and simple manual skills; does not progress in functional reading or arithmetic.	Can perform simple tasks under sheltered conditions; participates in simple recreation; travels alone in familiar places; usually incapable of self maintenance.
MILD	Often not noticed as retarded by casual observer, but is slower to walk, feed self and talk than most children.	Can acquire practical skills and useful reading and arithmetic to a 3rd to 6th grade level with special education. Can be guided toward social conformity.	Can usually achieve social and vocational skills adequate to self maintenance; may need occasional guidance and support when under unusual social or economic stress.

Mental retardation may result from any condition which interferes with the prenatal development of the brain, or which injures its structure after birth. In addition, within an unfavorable emotional or cultural environment, the individual's intellectual development may be seriously impeded.

**IN 3 OUT OF 4 MENTALLY RETARDED PERSONS,
THE CAUSES ARE NOT YET CLEARLY KNOWN**



ONLY ONE HAS

**KNOWN
BRAIN DAMAGE**

In approximately 15 to 25 percent of the cases of mental retardation, a specific disease entity can be held responsible. The impact of such diseases can be most readily demonstrated in those instances where there has been gross brain damage and where the degree of retardation is profound or severe. It is uncertain to what extent these organic factors operate to produce minor impairment among the less severely retarded.

When German measles occurs during the first three months of pregnancy, it sometimes results in damage to the fetus. Other infections occurring during pregnancy have also been implicated.

Infectious diseases of infancy and childhood, such as many forms of meningitis, encephalitis, measles, etc., may cause damage to the central nervous system, resulting in retardation.

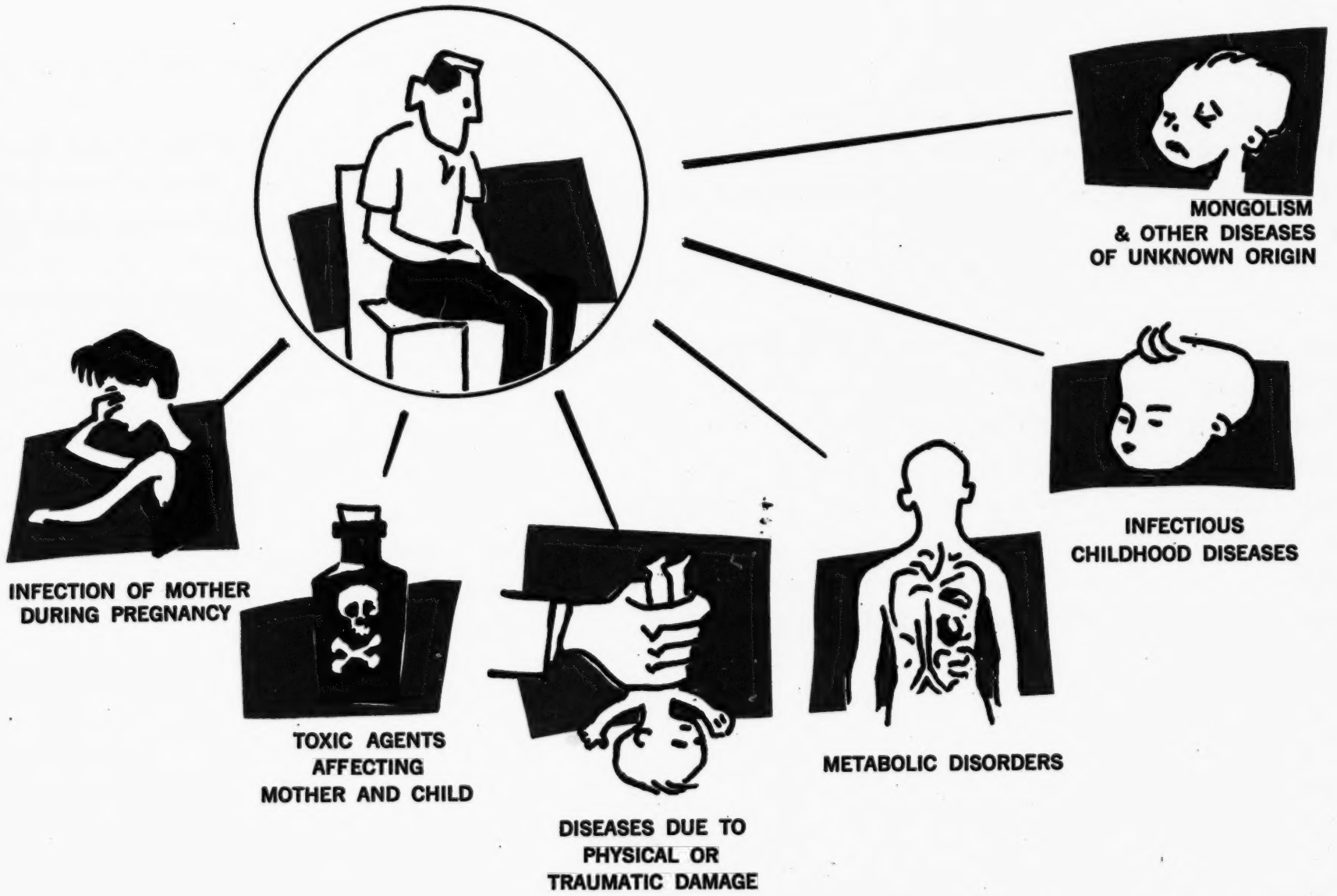
Jaundice of the newborn due to Rh blood factor incompatability is one factor. Carbon monoxide or lead poisoning are examples of toxic agents inhaled or ingested by the mother during pregnancy or by the child after birth, which also cause brain damage.

Diseases due to physical or traumatic agents include injuries occurring in difficult deliveries. Lack of oxygen, particularly in the premature baby, is another cause. Brain injury in childhood, particularly from automobile accidents, is an added factor.

A number of metabolic disorders, some of which are determined by heredity, produce mental retardation. These include phenylketonuria, in which there are abnormalities of amino acid chemistry in the body, and galactosemia, where there is a carbohydrate abnormality.

Diseases due to unknown prenatal factors include Mongolism, which results from abnormal chromosomal groupings probably at the time of the formation of the ovum in the mother. In addition, there is a sizeable group in which the causes of brain pathology are presently unknown.

BRAIN DAMAGE CAN BE DUE TO MANY CAUSES



About 75 to 85 percent of those now diagnosed as retarded show no *demonstrable* gross brain abnormality. They are, by and large, persons with relatively mild degrees of retardation.

A variety of factors appear to be operating within this large category.

Minor degrees of brain damage, too subtle to be demonstrated by currently available techniques, may be an underlying factor in some instances. However, unfavorable environmental and psychological influences are thought to play an important contributory role among this group. Such influences include interference with normal emotional and intellectual stimulation in early infancy, unfavorable psychological or emotional experiences in early childhood, and lack of normal intellectual and cultural experiences during the entire developmental period.

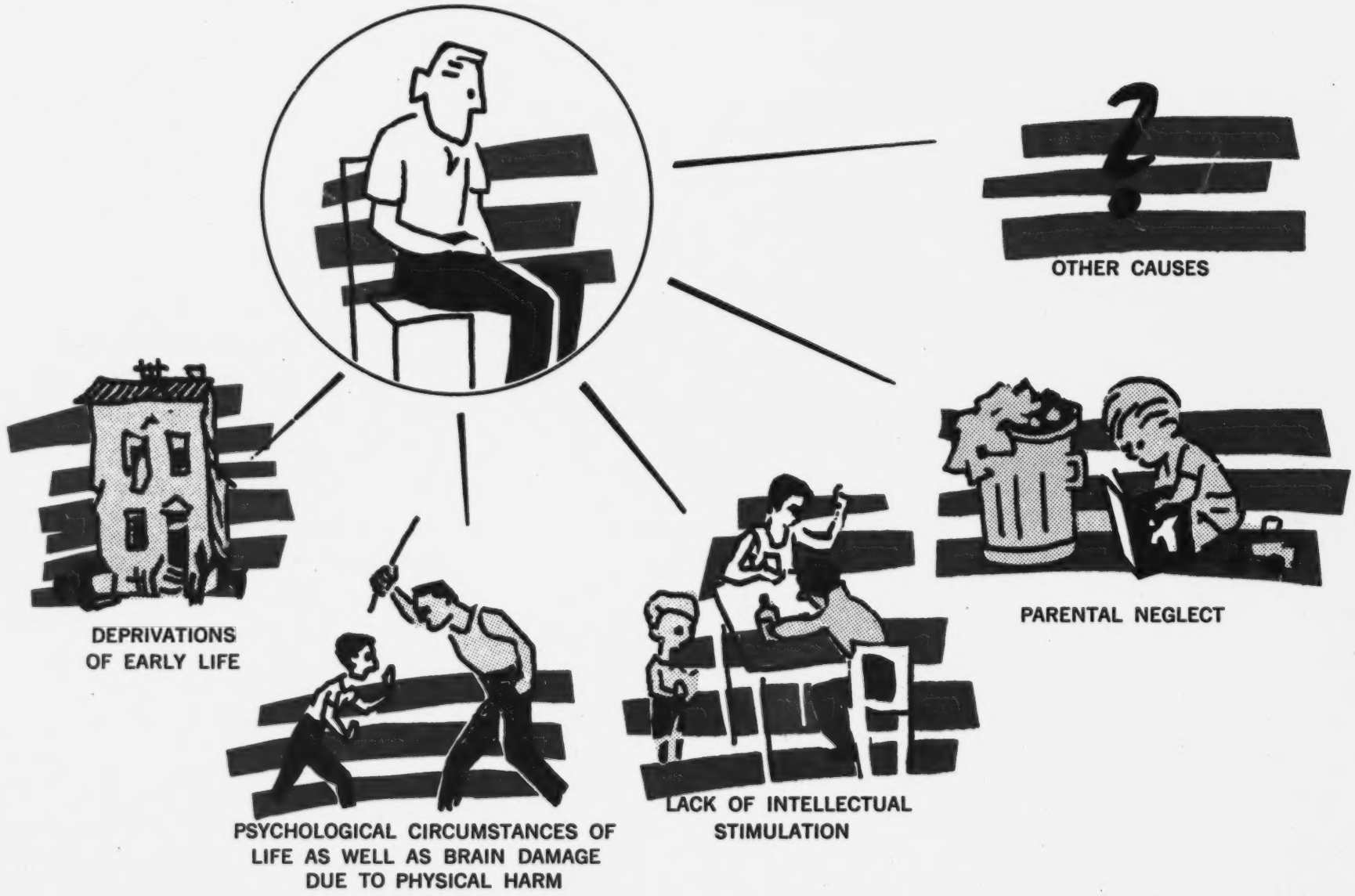
At the present time it is impossible to assign clear weights to each of the general causative factors. In many instances, multiple factors may be interacting within a single individual. All of them, however, operate more strongly among underprivileged groups than among those more favorably situated in society.

Many of these environmental and psychological variables can be ameliorated.

Some of these conditions are preventable if treatment can be instituted early enough in a child's life. Early identification, therefore, is essential.

Most of the remainder can also be ameliorated through a combination of resources—medicine, education, rehabilitation, and social work.

SOME ENVIRONMENTAL AND PSYCHOLOGICAL FACTORS LEADING TO RETARDATION


OTHER CAUSES
DEPRIVATIONS OF EARLY LIFE
PARENTAL NEGLECT
PSYCHOLOGICAL CIRCUMSTANCES OF LIFE AS WELL AS BRAIN DAMAGE DUE TO PHYSICAL HARM
LACK OF INTELLECTUAL STIMULATION

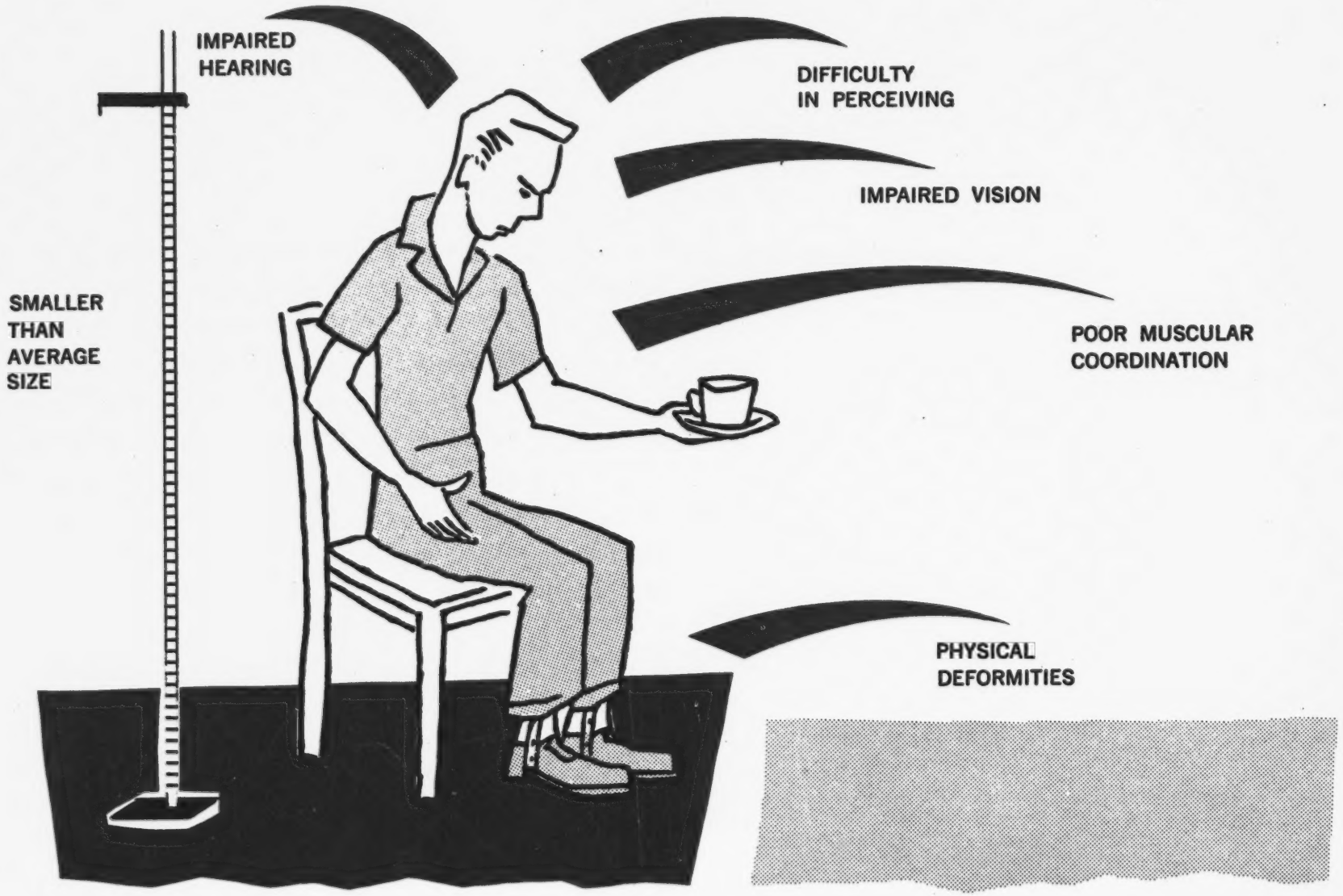
Data on patients in institutions show a higher prevalence of pathological conditions among the more severely retarded.

Current reports from clinical programs dealing with retarded children under six years of age indicate that 75 percent have associated physical disabilities.

Many of these retarded persons are multi-handicapped.

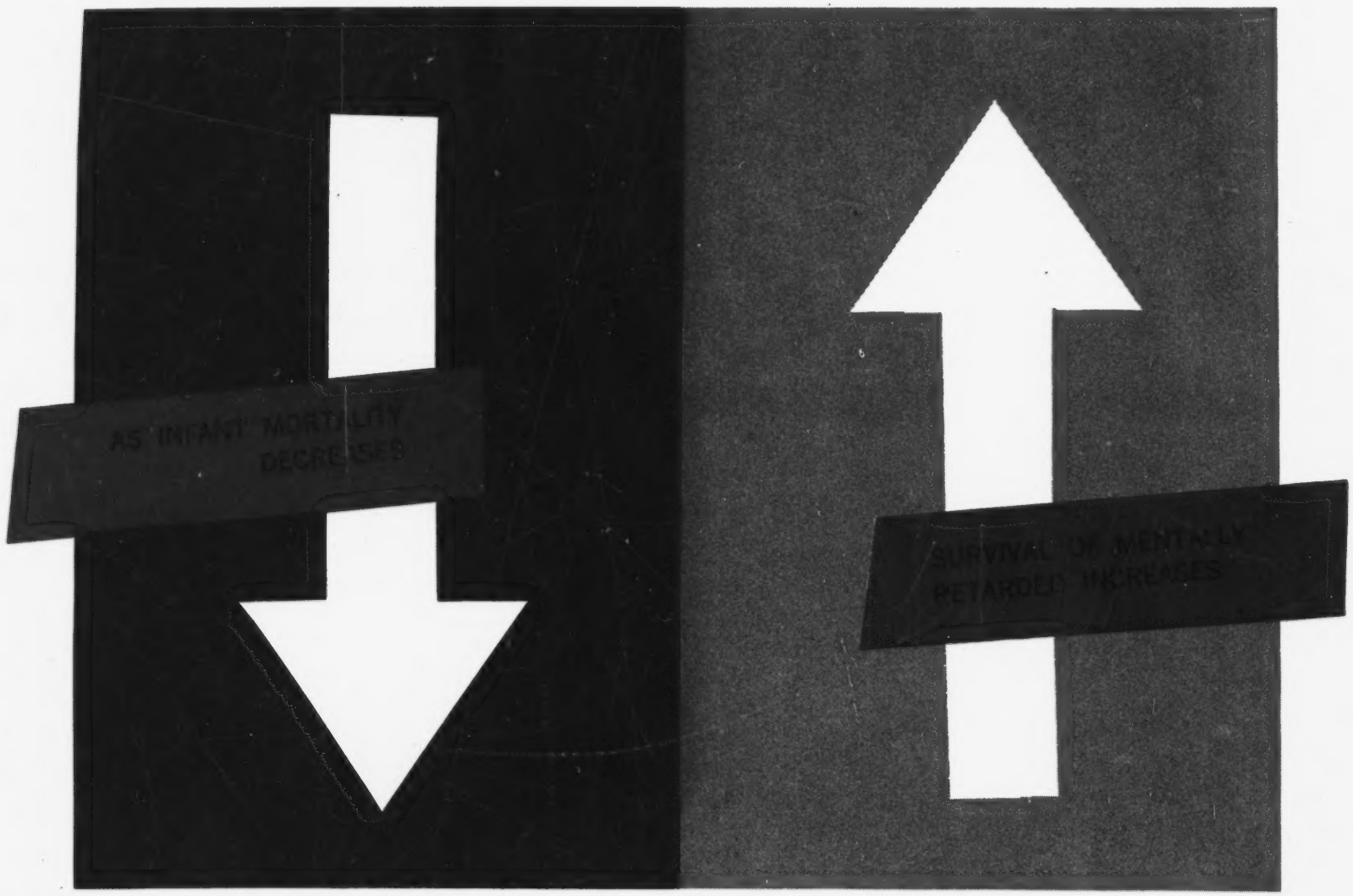
The increased survival rates of retarded infants will probably increase the number of retarded persons with associated physical handicaps.

A LARGE PERCENTAGE OF SEVERELY MENTALLY RETARDED HAVE ADDITIONAL HANDICAPS



Modern medical care and other factors have helped decrease the infant mortality rate in the United States by 75 percent in the past 20 years. At the same time, the survival rate of the mentally retarded has increased. More infants who are born prematurely and who have congenital handicaps are surviving. Mental retardation is one of the conditions suffered by some of these children. New research, improved and more extensive prenatal and postnatal care, coupled with disease and radiation control, better drugs and higher standards of living can help reduce retardation from such birth abnormalities.

MEDICAL SKILLS HELP MENTALLY RETARDED SURVIVE



Progress has been made in identifying specific conditions and diseases and in establishing basic problems of behavior and learning.

A chromosome abnormality has been discovered in Mongolism, but the cause is still unknown. While many research projects are now underway, much broader knowledge must be achieved before there will be adequate understanding of the pathological, genetic, psychological, environmental and other aspects of mental retardation.

BIOLOGICAL BREAKTHROUGHS IN THE PREVENTION OF MENTAL RETARDATION

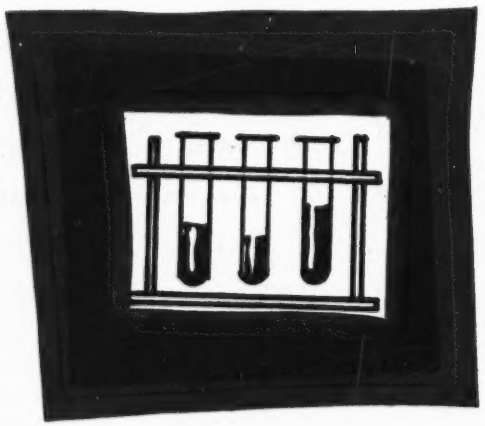
SURGICAL

HYDROCEPHALUS

CRANIO STENOSIS

BIO-CHEMICAL METHODS

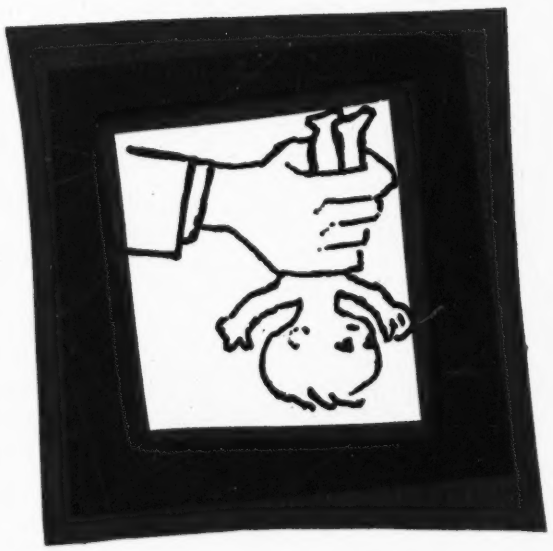
CONTROLLED THROUGH DIET



GALACTOSEMIA

PHENYLKETONURIA

OTHERS



JAUNDICE DUE TO
R H FACTOR

Accurate diagnosis is an essential prelude to the treatment of mental retardation. However, only gross impairment is evident in early childhood. This generally involves failure to walk and talk at appropriate times.

Surveys show that in most instances, intellectual deficit does not become apparent until the child goes to school. This generally becomes evident by inability to perform kindergarten or first-grade work.

Social inadequacy is frequently not recognized until adolescence.

THREE MAJOR MEANS BY WHICH THE MENTALLY RETARDED CAN BE IDENTIFIED

MEDICAL DIAGNOSIS
MOSTLY OF THE SERIOUSLY RETARDED AT PRE-SCHOOL AGE

SCHOOL TESTS AND UNDER ACHIEVEMENT

RECOGNITION OF SOCIAL INADEQUACY

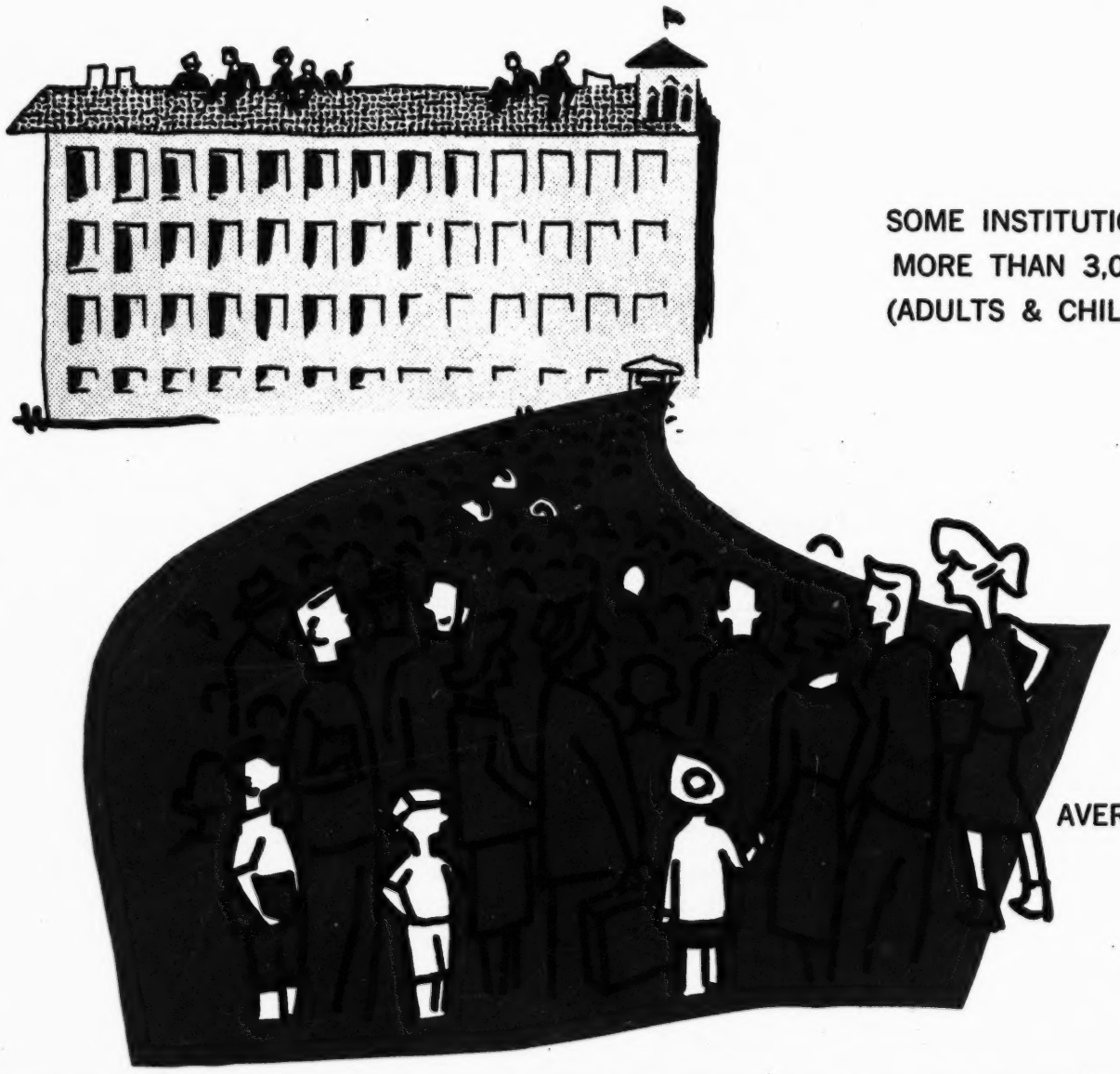
There are some 210,000 mentally retarded patients in residential institutions.

In 1960 approximately 160,000 were in State institutions for the retarded; 40,000 were in hospitals for the mentally ill; and 10,000 were in private institutions.

There are approximately 10 percent more mentally retarded patients in residential institutions than there were 5 years ago.

The average waiting list continues to grow and the quality of service often suffers from limited budgets, low salary levels, and severe personnel shortages.

STATE INSTITUTIONS FOR MENTALLY RETARDED ARE OVERSIZED AND OVERCROWDED



SOME INSTITUTIONS ACCOMMODATE
MORE THAN 3,000 PATIENTS
(ADULTS & CHILDREN)

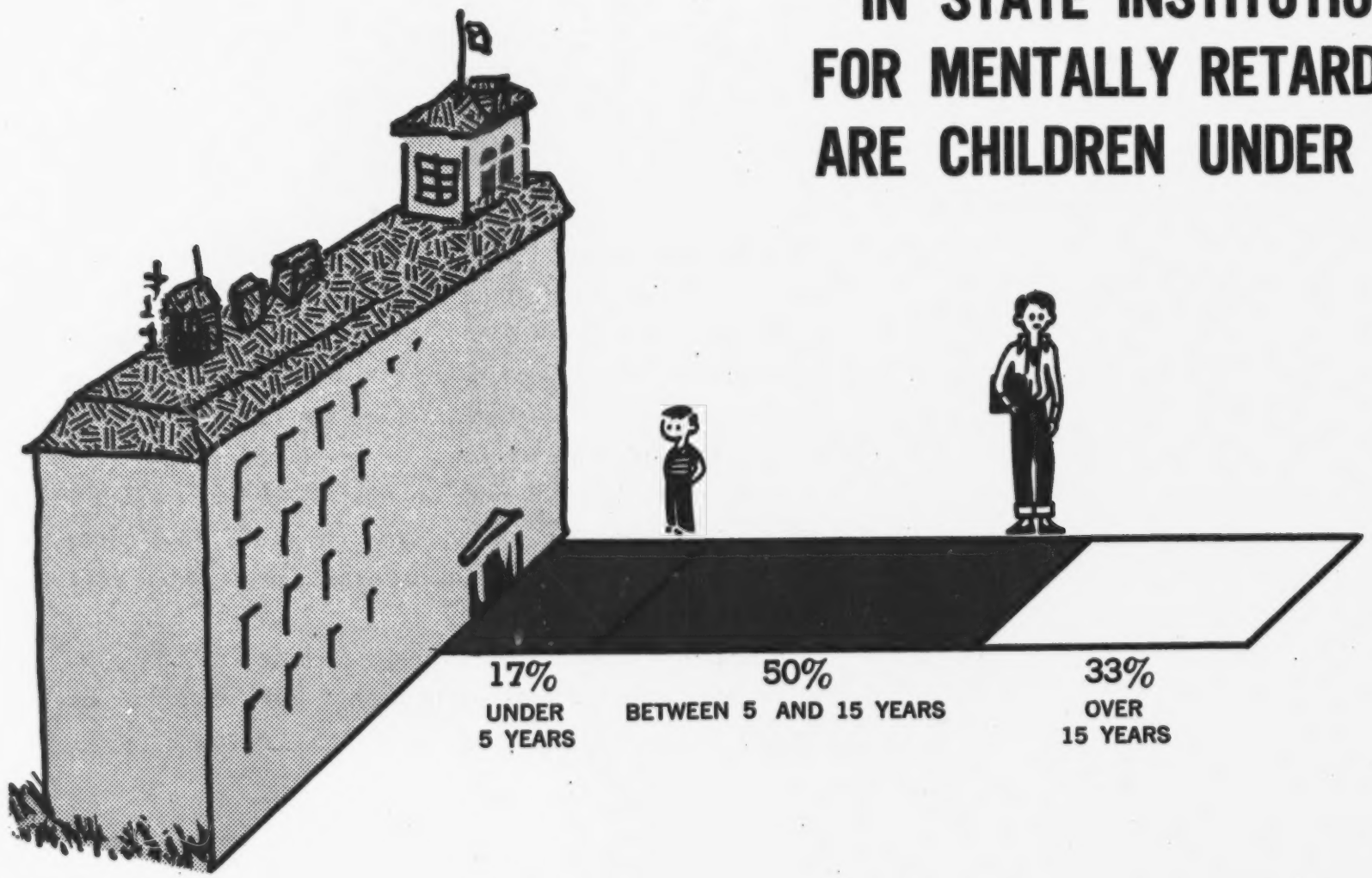
AVERAGE WAITING LIST: 340

AVERAGE WAITING TIME: 3 YEARS

In recent years, those being admitted to institutions are more severely retarded and of younger age than formerly. At present:

- Approximately 67 percent of admissions are children under 15 years of age.
- New admissions are largely less than 9 years of age.
- The median of admission is under 11 years of age.

TWO OUT OF THREE FIRST ADMISSIONS IN STATE INSTITUTIONS FOR MENTALLY RETARDED ARE CHILDREN UNDER 15



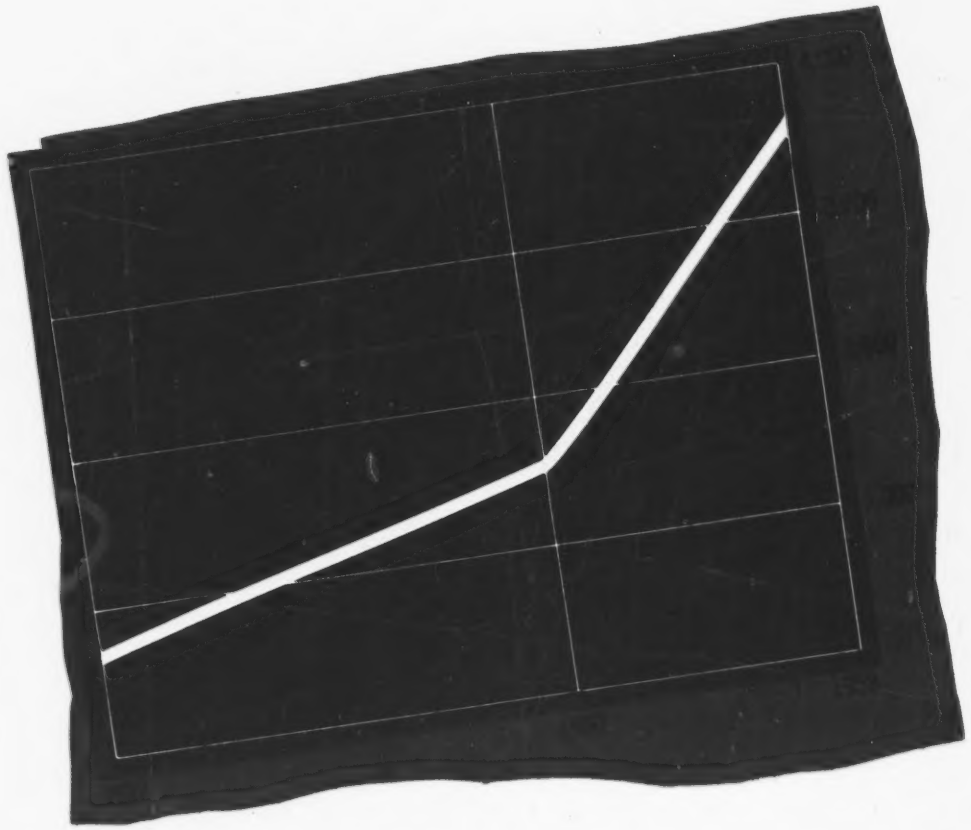
BASED ON 1959 FIGURES

Education is vital in helping to prepare the mentally retarded for productive lives.

While the number of mentally retarded enrolled in special educational classes has doubled over the past decade, many more such facilities must be provided. Only about 20 percent of retarded children have access to special education.

Some States do not provide any classes for the "trainable" retarded, and no State has sufficient classes for the "educable" retarded. It is important to break down rigid barriers between these two groups.

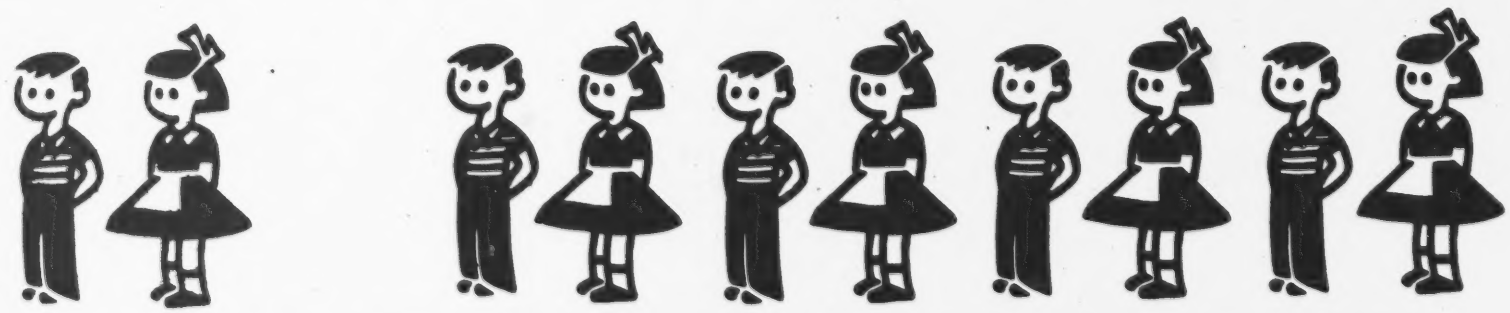
Research in special curricula, teaching machines and other advanced methods of pedagogy for this group has lagged.



SPECIAL EDUCATION HAS MADE PROGRESS

NUMBER OF LOCAL PUBLIC SCHOOL SYSTEMS
HAVING SPECIAL EDUCATION PROGRAMS

BUT . . . IT REACHES ONLY



TWO OUT OF TEN MENTALLY RETARDED CHIILDREN

There are not enough teachers to meet the need for special educational classes. Many of today's teachers have not fully met professional standards.

Special education classes need teachers trained in the specific needs and problems of the retarded.

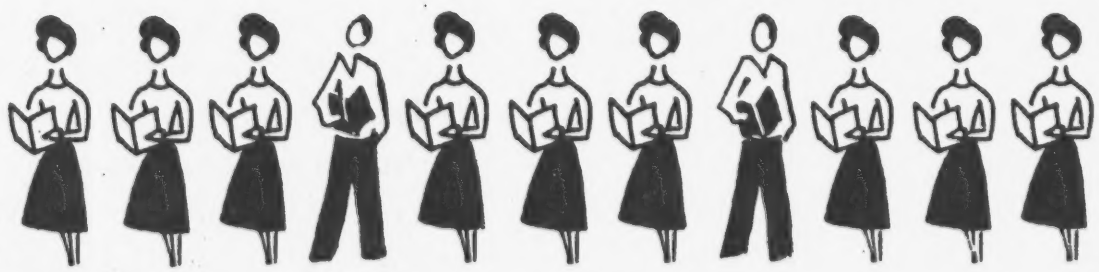
Some foreign countries with advanced programs in the field of retardation offer special bonuses to teachers of the retarded. A few of our States have begun experimenting with special benefits to attract more teachers into this field.

THE GROWING NEED FOR SPECIAL EDUCATION TEACHERS

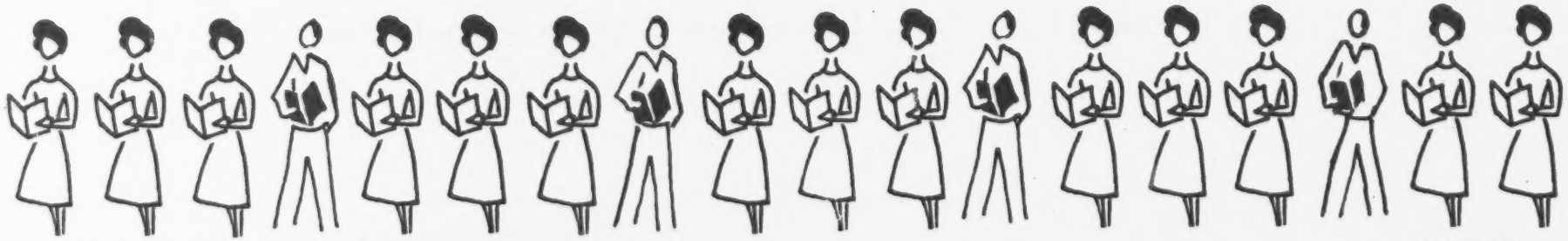
PRESENT STAFF

20,000

ADDITIONAL TEACHERS NEEDED
TO REACH ALL CHILDREN NOW



55,000



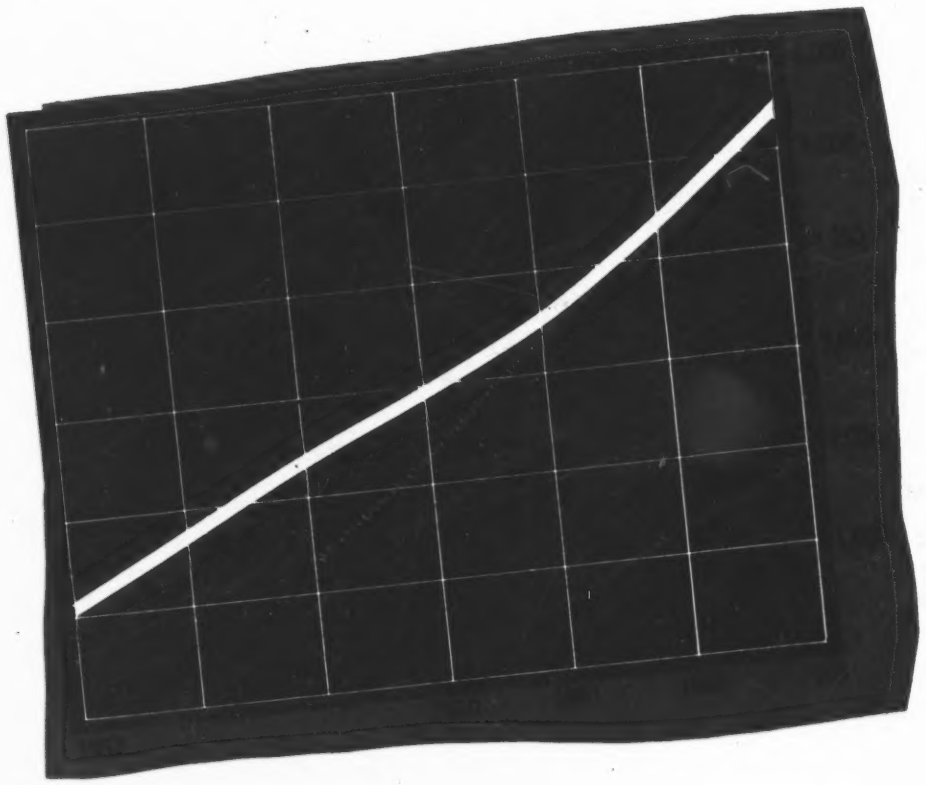
TOTAL NUMBER OF TEACHERS NEEDED BY 1970

90,000

Only a fraction of the mentally retarded receive vocational rehabilitation training.

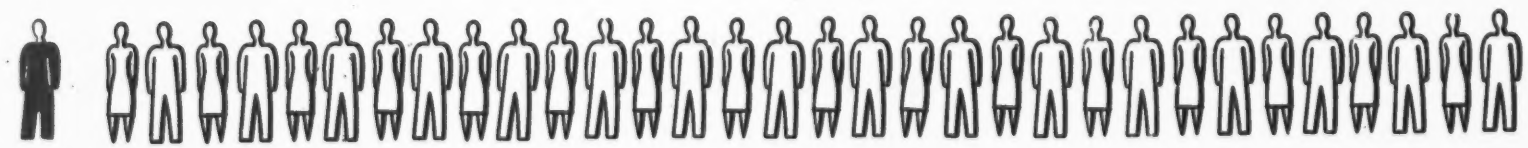
In 1961, it was estimated that 42 States had only 200 sheltered workshops serving exclusively the mentally retarded under various auspices.

Over 25 percent of those who receive vocational rehabilitation cannot be placed in jobs. New techniques in training for competitive industry are needed. In addition, communities should provide adequate workshop facilities to meet the needs of the retarded who cannot be placed in regular employment but can do useful work in a sheltered setting.



VOCATIONAL REHABILITATION OF THE RETARDED THROUGH STATE VOCATIONAL AGENCIES HAS MADE SOME PROGRESS

BUT . . . IT REACHES ONLY



3% OF ALL MENTALLY RETARDED

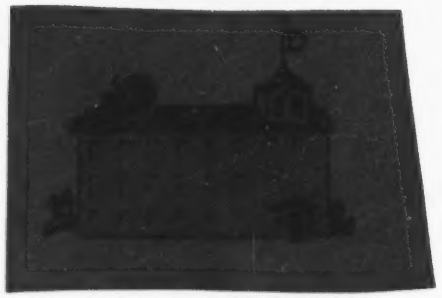
Today, the effort to meet the problem of mental retardation takes several forms. All services are in short supply. Priority areas for action include:

- *Research.* Expanded research in the biological and behavioral sciences is vital.
- *Diagnostic and clinical programs.* Present services must be extended where needed and new ones established.
- *Services and care* for those in *residential institutions.* These need to be improved and expanded.
- *Day care, recreation and social services* for the retarded must be augmented, and a variety of new services should be devised.
- *Home care and parent guidance.* Such programs offer bright prospects for helping parents to meet their social and emotional needs.
- *Special education and vocational rehabilitation.* Both programs currently serve only a small percentage of those who could benefit from such services.
- *Personnel.* Shortages of qualified personnel remain one of the major bottlenecks in providing services to retarded persons and their families.

DIAGNOSTIC AND
CLINICAL SERVICES

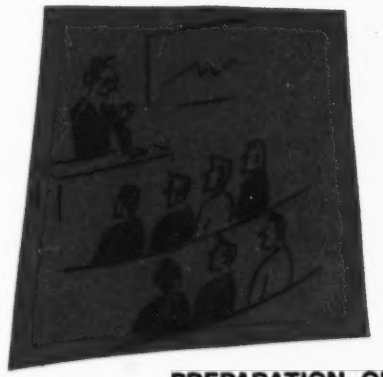
RESEARCH

DAY CARE, RECREATION



CARE IN RESIDENTIAL
INSTITUTIONS

NEEDED AREAS
OF ACTION



PREPARATION OF
PROFESSIONAL PERSONNEL

SPECIAL EDUCATION

HOME CARE
PARENT GUIDANCE

MATERNAL AND
INFANT CARE

VOCATIONAL
REHABILITATION

Research

Extended research in the biological and behavioral sciences is needed. Such research needs to be both generic and specific and should include research in teaching and learning.

Flexibility of pattern and structure, as well as in research emphasis are essential to the establishment of the proposed research centers in mental retardation.

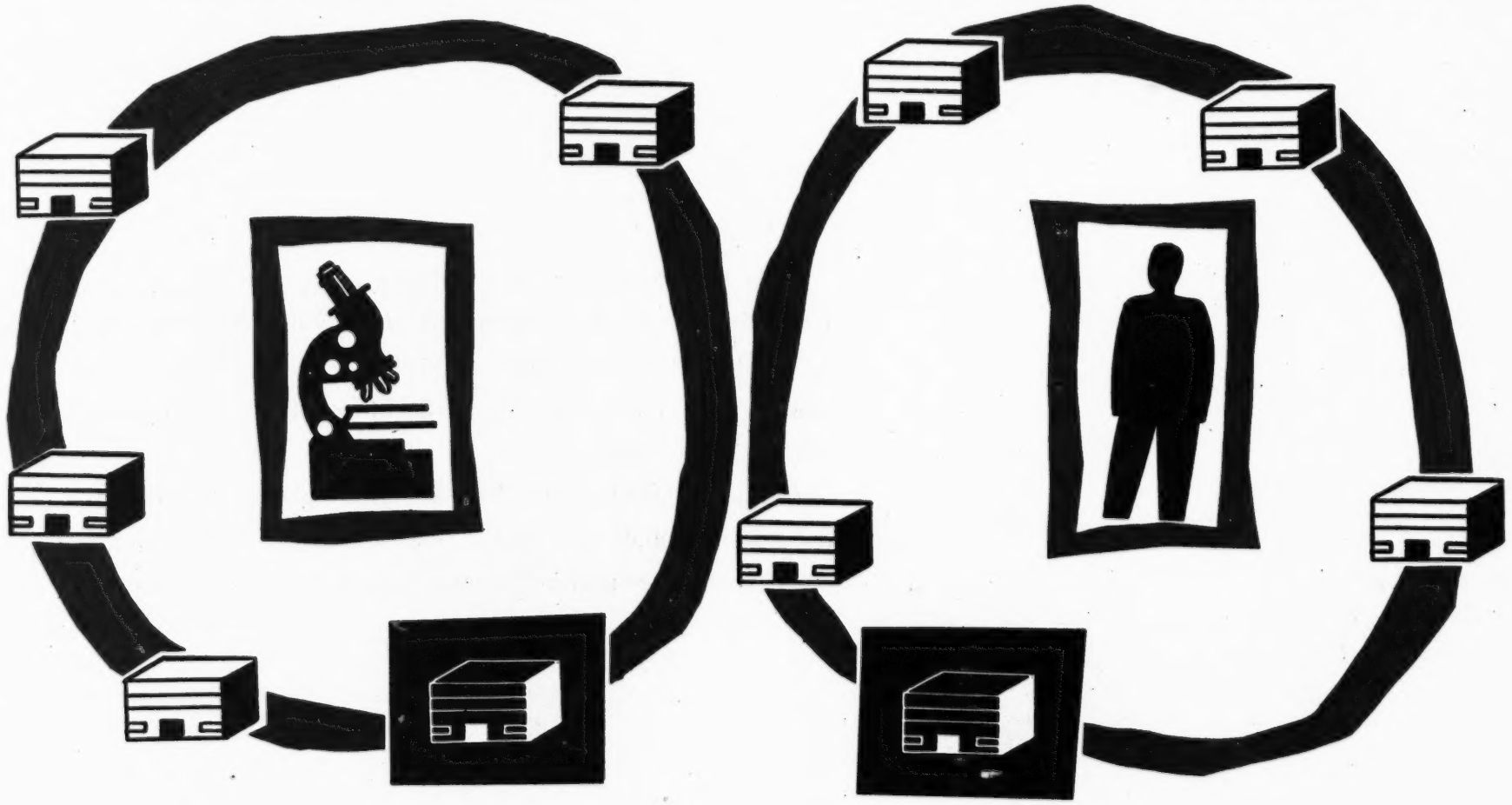
Some of the research centers mentioned on the opposite page might be institution centered, but with some form of university affiliation. Universities should be selected where there is an interest in mental retardation and a record of effective cooperation among the biological, social and behavioral scientists.

These centers will provide basic research, clinical and psychological research, personnel training, and some patient care.

RESEARCH CENTERS

IN THE BIOLOGICAL SCIENCES

IN THE BEHAVIORAL AND SOCIAL SCIENCES



ALL SHOULD COOPERATE AND SHARE FINDINGS

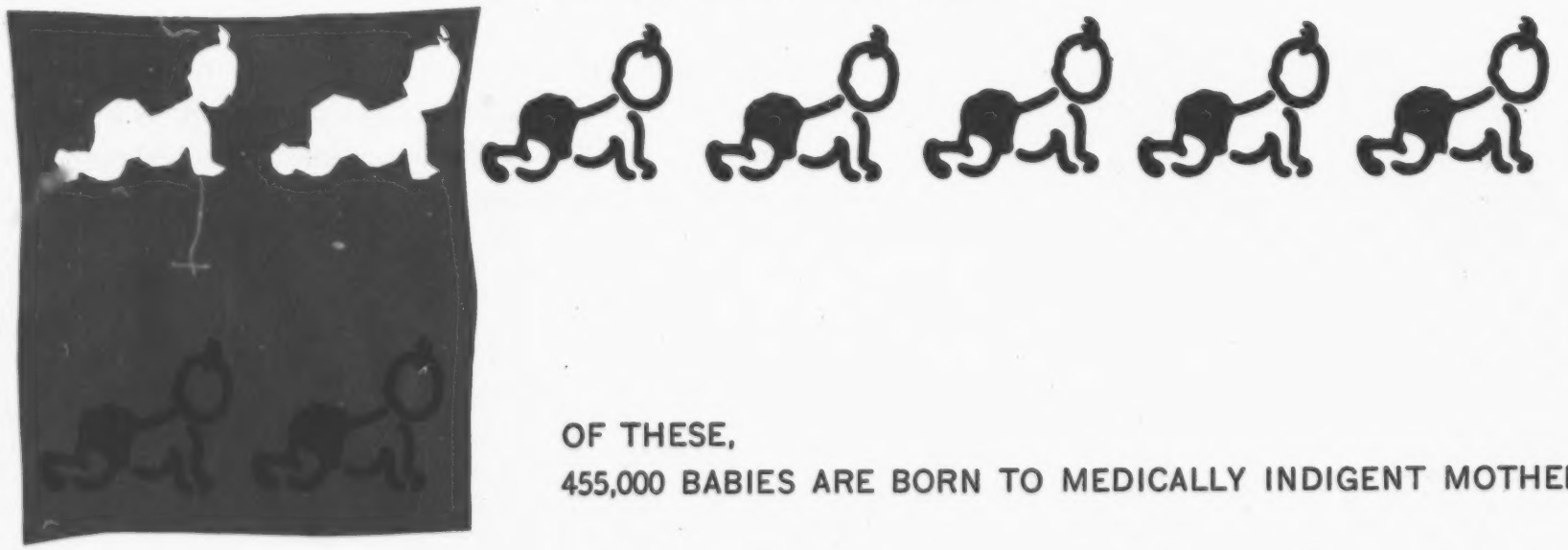
The 138 cities in the United States with populations over 100,000 account for approximately 1,300,000 births each year. This is about 35 percent of all births in the Nation annually. Of this number, about 455,000 mothers (30 percent) are medically indigent.

About 100,000 of the 455,000 also have some complications in pregnancy and need special services. This includes unmarried mothers under 20 who also need special services.

COMPREHENSIVE MATERNAL AND INFANT CARE
FOR "HIGH RISK" PREGNANCY CASES IN LOW-INCOME GROUPS

IN THE 138 LARGEST CITIES WHERE THE NEED IS GREATEST

1,300,000 BABIES ARE BORN EVERY YEAR



OF THESE,
455,000 BABIES ARE BORN TO MEDICALLY INDIGENT MOTHERS

Prevention

A greatly strengthened program of maternal and infant care is recommended. Initially this should be aimed at those centers of population where miscarriage, prematurity and the rate of damaged children are high. It should provide better diagnostic services and protection against the known hazards to pregnancy. Services should be provided in neighborhoods where the needs are greatest.

OUT OF 455,000 MEDICALLY INDIGENT MOTHERS

100,000 NEED SPECIAL SERVICES

BEFORE, DURING OR AFTER BIRTH

THIS PROPOSED PREVENTIVE PROGRAM IS ESTIMATED TO COST APPROXIMATELY
$300 PER PATIENT PER YEAR

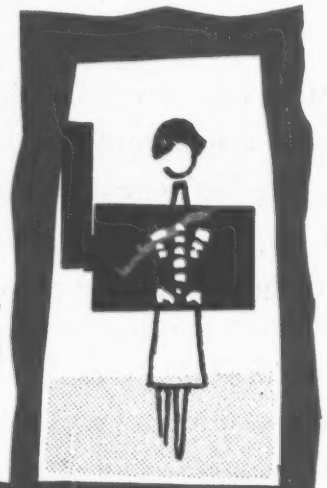
Stringent precautions by appropriate public authorities, by physicians and commercial firms are needed to insure the best possible protection of mothers and children. For example, all x-ray equipment should be thoroughly and regularly checked to eliminate the possibility of "leakage" that might be harmful during pregnancy and childhood; present testing procedures for drugs should be rigorously reviewed to determine whether they furnish sufficient evidence as to their possible effect on the unborn child; State and local authorities should institute a continuing surveillance over the problem of paint ingestion by children and insure that paint used on cribs, toys and similar equipment contains no lead.

Increased sensitivity is needed among physicians to the special hazards faced by women of child-bearing age.

In addition, measures need to be refined and extended for the early detection and treatment of such metabolic disorders as phenylketonuria, the galactosemias and others. As research adds to our present knowledge, other preventive procedures of this type will be possible.

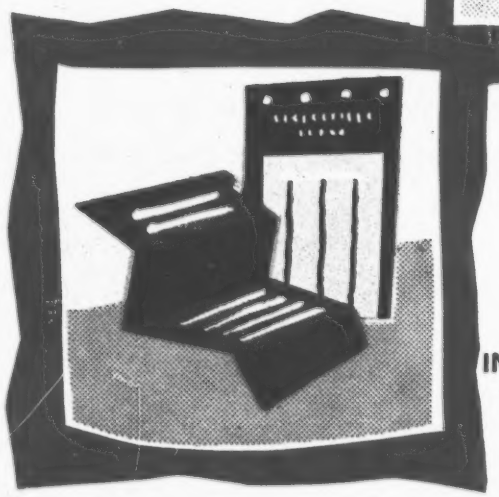
PROTECTION DURING PREGNANCY FROM RADIATION AND HARMFUL DRUGS

LICENSING OF ALL RADIATION EQUIPMENT WITH INSPECTION

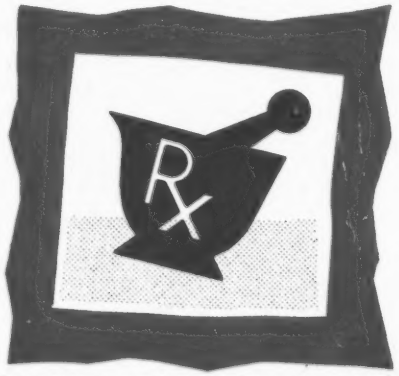


INTENSIVE EDUCATION PROGRAM ON RADIATION DANGERS

REPLACEMENT OF FLUOROSCOPY EQUIPMENT BY IMAGE INTENSIFIERS



INDIVIDUAL RADIATION RECORDS



MORE STRINGENT EVALUATION OF NEW DRUGS FOR EFFECT ON NEWBORN

Residential care must be changed to more adequately meet the needs of the retarded. Small, residential units having 500 beds, accessible to or in urban areas, and combined residential and day care units should gradually replace large institutions isolated from the centers of population.

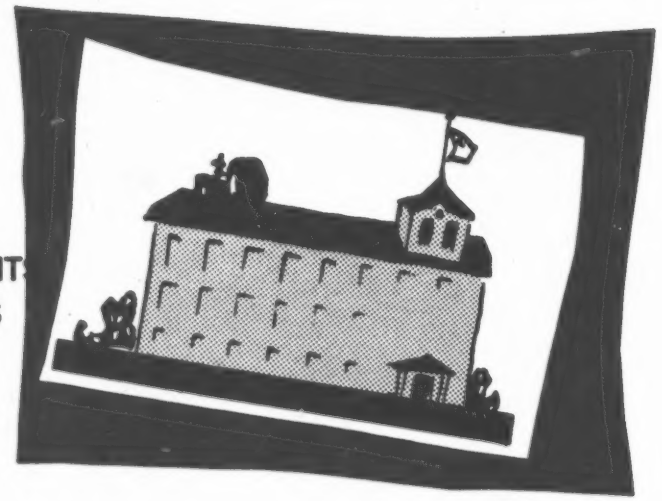
Special efforts should be made to return the institution to the community. Regional centers within each State will require a combination of programs, including residential, day care, diagnostic and parent counseling services to all who need it in the region. Emphasis should be on care in the home and development of a wide range of community facilities.

Such facilities should be close to teaching and research facilities.

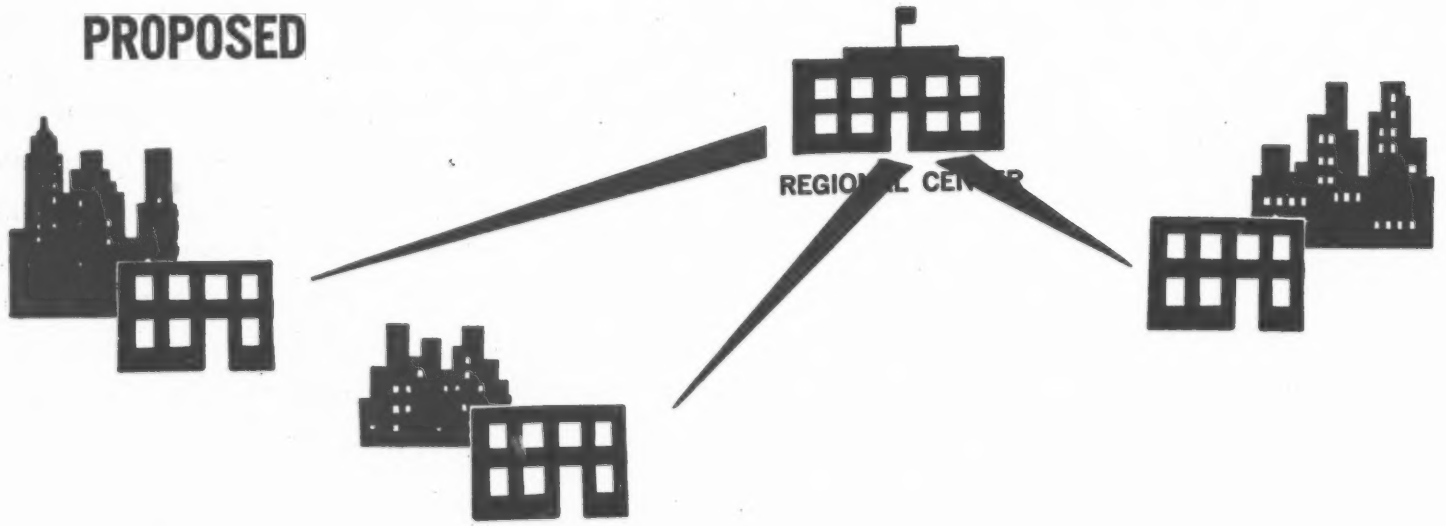
CHANGES IN RESIDENTIAL CARE

AT PRESENT

MANY LARGE INSTITUTIONS
IN REMOTE LOCATIONS
LONG DISTANCE FROM PARENTS
AND COMMUNITY RESOURCES



PROPOSED



SMALL, ACCESSIBLE CENTERS IN EACH STATE PROVIDING DAY CARE PARENT COUNSELING AND TREATMENT OF THE RETARDED CLOSER TO THEIR OWN HOMES

Enriched and expanded programs of special education for the retarded in public and private schools are essential. These should be closely coordinated with vocational guidance and specific preparation for employment (or a productive occupation) by a planned workshop experience.

Appropriate adult education should be provided for the mentally retarded who have not had earlier educational opportunities, or who can profit by additional opportunities.

While every State now has some special education program for mentally retarded pupils, no State provides more than a fraction of necessary services. Federal grants to States for special school services for the retarded should be administered through an expansion and improvement program and awarded on the basis of competitive application.

ENRICHED PROGRAM OF SPECIAL EDUCATION FOR THE RETARDED

IN PUBLIC AND PRIVATE SCHOOLS

SPECIAL EDUCATION CLASSES

VOCATIONAL GUIDANCE & WORKSHOP CLASSES

EXTENSION COURSES FOR ADULTS

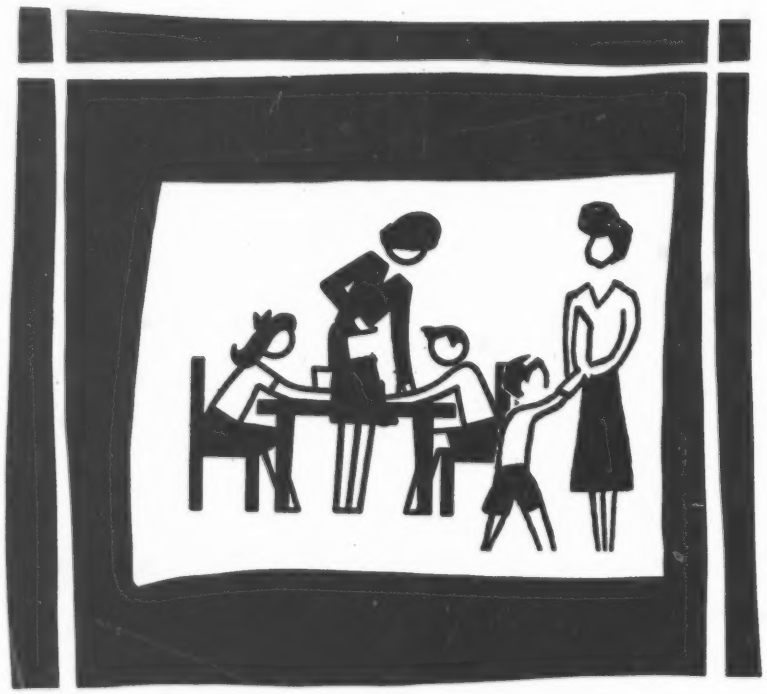
There is a serious shortage of teachers of the mentally retarded.

Liberal scholarships should be provided to students who will be trained as special education teachers. Promising students should be enabled to apply for scholarship grants to universities and colleges having qualified staffs. The major scholarship stipend should be provided for training beyond the four years required for a baccalaureate degree. As a recruitment incentive, where interest is indicated, modest stipends might be made to juniors and seniors in college.

Careful attention should be paid to the experience of those States now experimenting with offering special bonuses to teachers of the retarded.

INCENTIVES
TO SPUR RECRUITMENT OF TEACHERS FOR THE RETARDED

LIBERAL SCHOLARSHIPS FOR
TRAINING IN SPECIAL EDUCATION



INCREASED APPROPRIATIONS FOR
IMPROVEMENT AND EXTENSION OF CLASSES

Vocational rehabilitation and workshop facilities must be greatly expanded. One method is to increase purchase of services by State rehabilitation agencies from sheltered workshops and other private rehabilitation services.

Plans for a long-range program should be initiated to provide sufficient funds for constructing and remodeling rehabilitation facilities and the purchase of appropriate equipment.

Grants for intramural research should be appropriated on a broader and more flexible basis.

Training of skilled personnel must be extended through scholarships.

Vocational guidance and specific employment preparation are needed. Communities and employers must be informed about the employment potentials of the retarded.

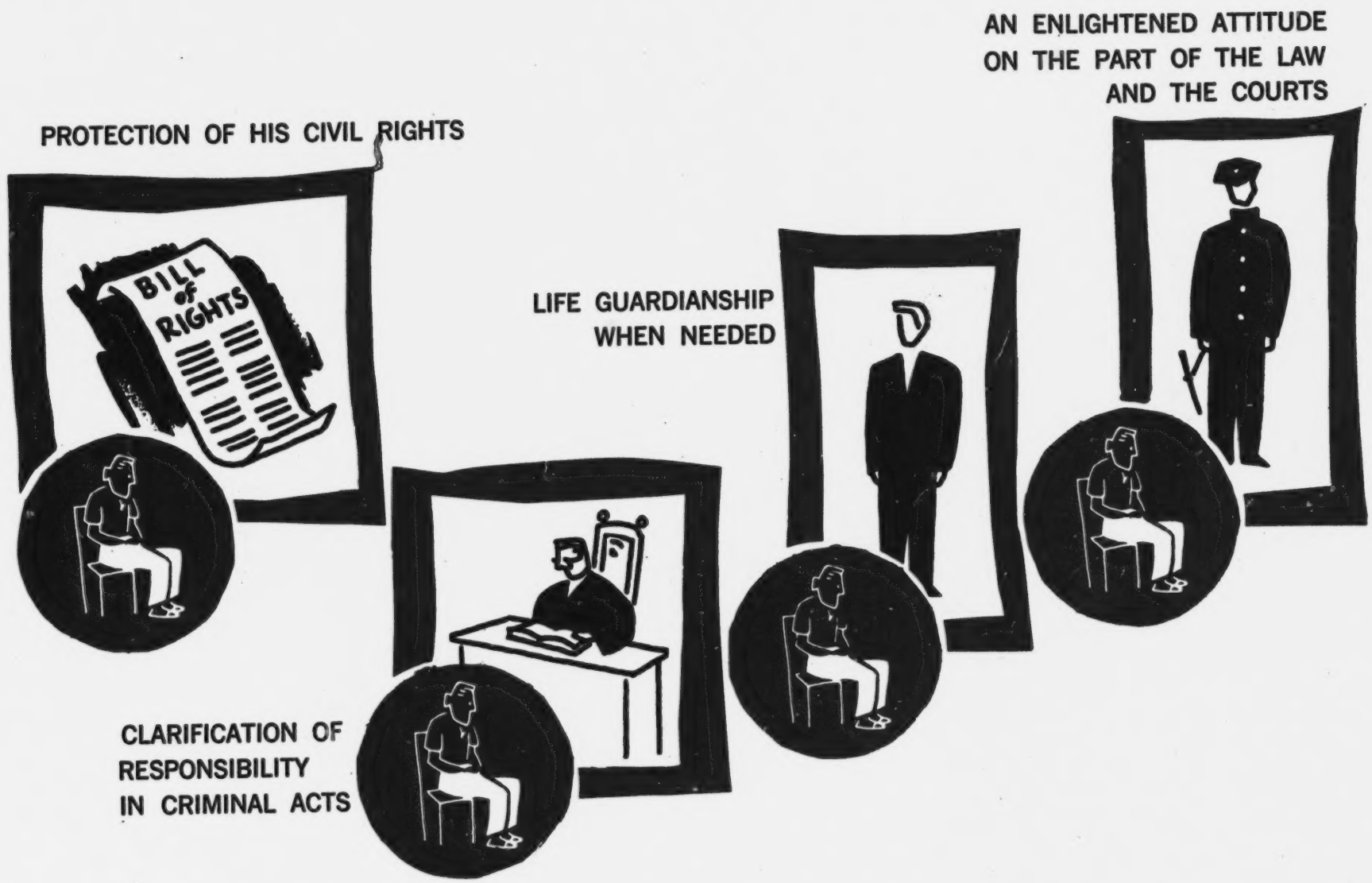
REHABILITATION AND TRAINING RECOMMENDATIONS
FOR MENTALLY RETARDED

Legal

A new legal as well as social concept of the retarded is needed. This concept should include:

- Protection of the civil rights of the retarded.
- Life guardianship provisions when needed.
- An enlightened attitude by the police and the courts in cases of minor conflict with the law.
- Clarification of the theory of responsibility in criminal acts as applied to the retarded.

A NEW LEGAL CONCEPT OF THE RETARDED

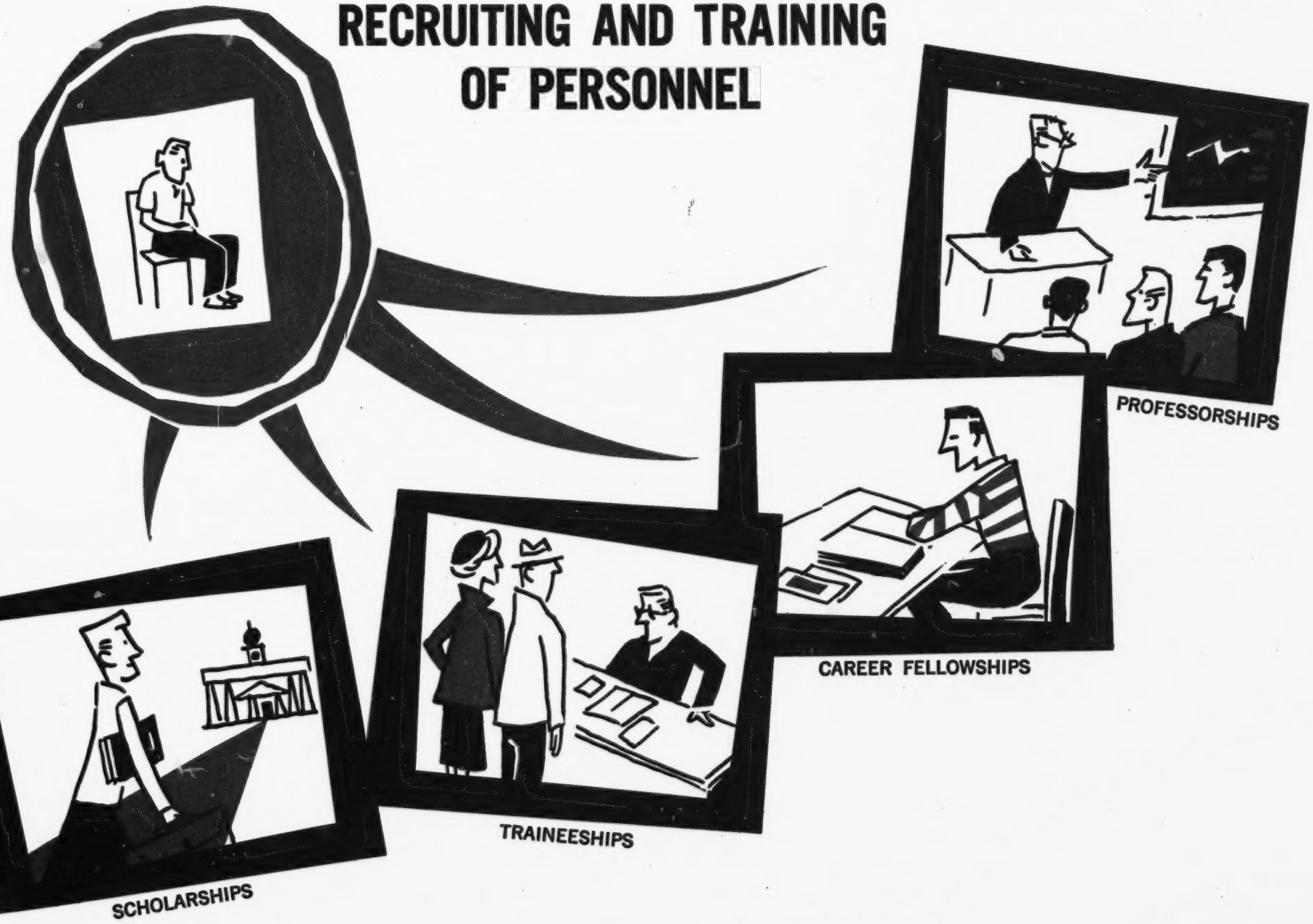


Personnel

An increase in the professional manpower pool is vital to expanded services for the mentally retarded. The supply of medical, research, teaching, rehabilitation and guidance personnel must be enlarged.

A stepped-up program of recruiting, utilizing such incentives as scholarships, fellowships, and traineeships, is essential.

RECRUITING AND TRAINING OF PERSONNEL



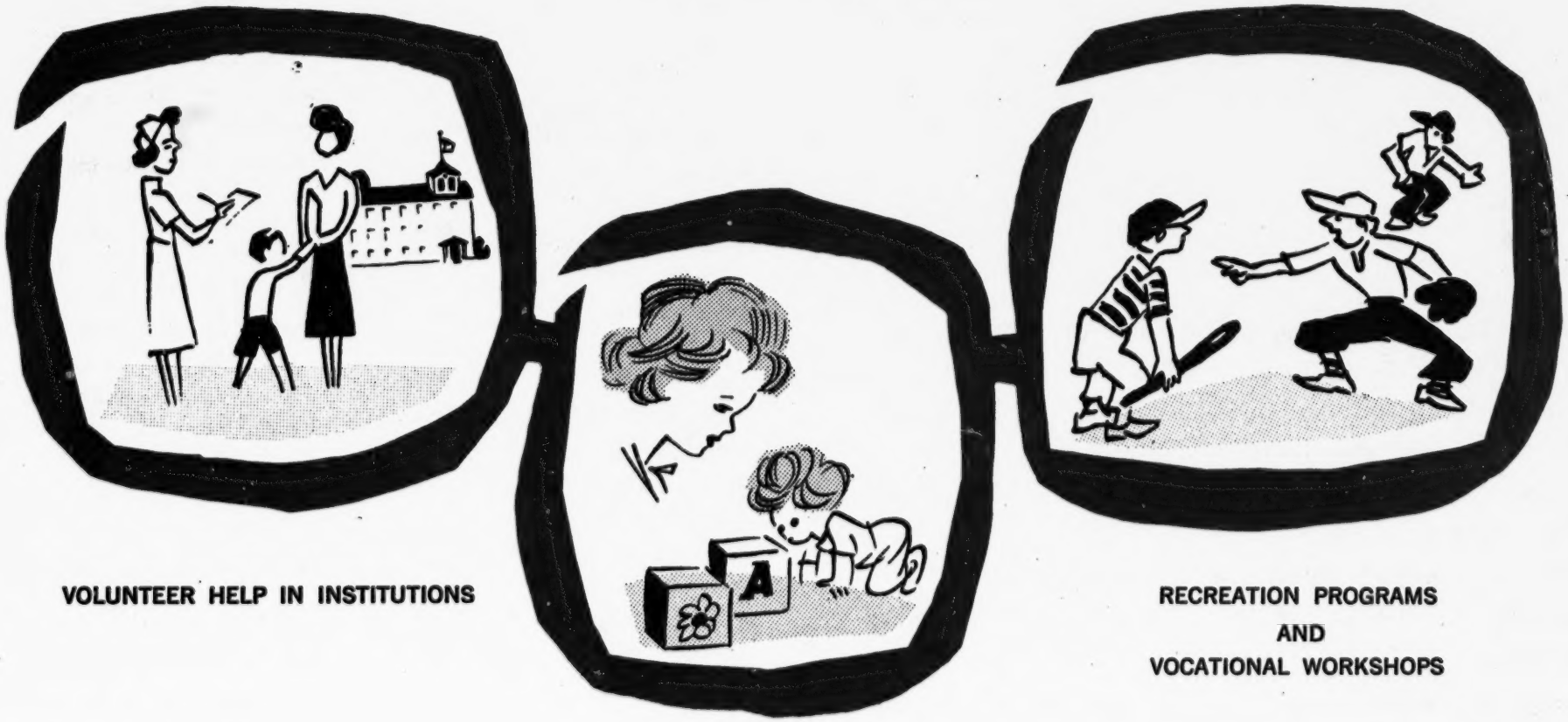
The Role of the Volunteer

Young people and mature adults, by volunteering their services, can help man needed community programs. They can contribute to increased education and rehabilitation and care of the mentally retarded in every community.

A National Service Corps is suggested as a means of recruiting and placing volunteers in this and related fields.

CREATION OF A NATIONAL SERVICE CORPS

From all walks of life to help man community services



VOLUNTEER HELP IN INSTITUTIONS

DAY CARE CENTERS

RECREATION PROGRAMS AND VOCATIONAL WORKSHOPS

Public Awareness

The findings and recommendations of the different task forces of the President's Panel on Mental Retardation need to be interpreted to appropriate professional organizations on an orderly, planned and continuous basis.

The role of particular professions in the field of mental retardation needs to be demonstrated.

Professional groups should be kept informed about the newest advances and techniques in their fields which relate to retardation.

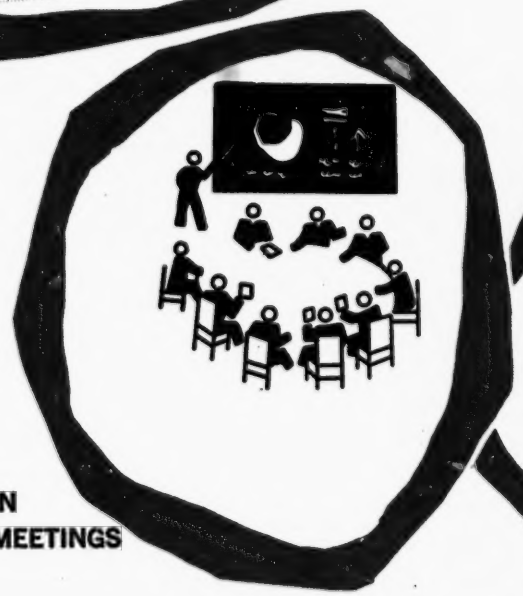
Among the national voluntary organizations and professional societies whose interests and activities relate closely to problems of the retarded are the following (partial listing):

- American Academy of General Practitioners
- American Academy of Neurology
- American Academy of Obstetrics and Gynecology
- American Academy of Pediatrics
- American Association on Mental Deficiency
- American Medical Association
- American Neurological Association
- American Orthopsychiatric Association
- American Psychiatric Association
- American Psychological Association
- American Public Health Association
- American Public Welfare Association
- Child Welfare League of America
- Council on Social Work Education
- Family Service Association of America
- Group for the Advancement of Psychiatry
- National Association for Mental Health
- National Association for Retarded Children—and 960 Local Affiliates
- National Association of School Boards
- National Association of Social Workers
- National Committee for Research in Neurological Disease
- National Education Association, including the Council for Exceptional Children
- National Health Council
- National Recreation Association
- National Rehabilitation Association
- National Social Welfare Assembly

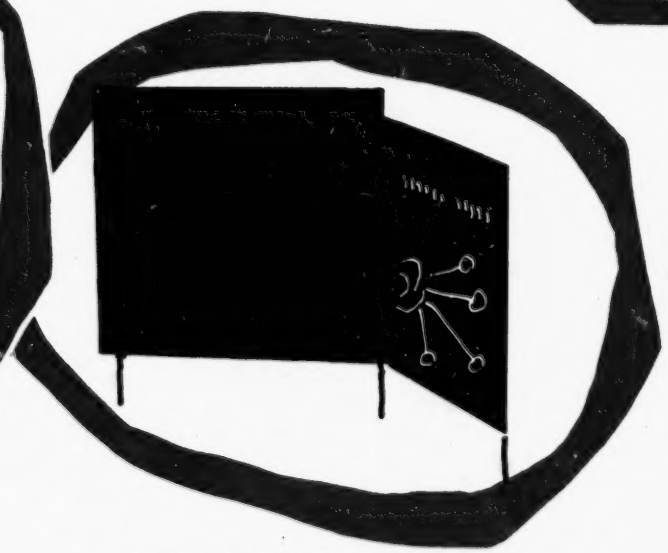
EDUCATION AND INFORMATION PROGRAM FOR PROFESSIONAL GROUPS

PUBLICATIONS IN PROFESSIONAL JOURNALS

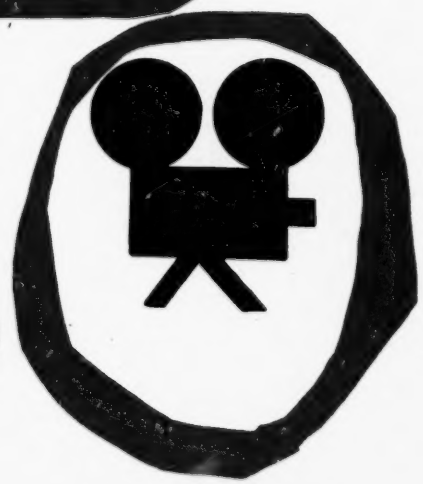
PRINTED MATERIALS



PARTICIPATION IN PROFESSIONAL MEETINGS



PREPARATION OF EXHIBITS



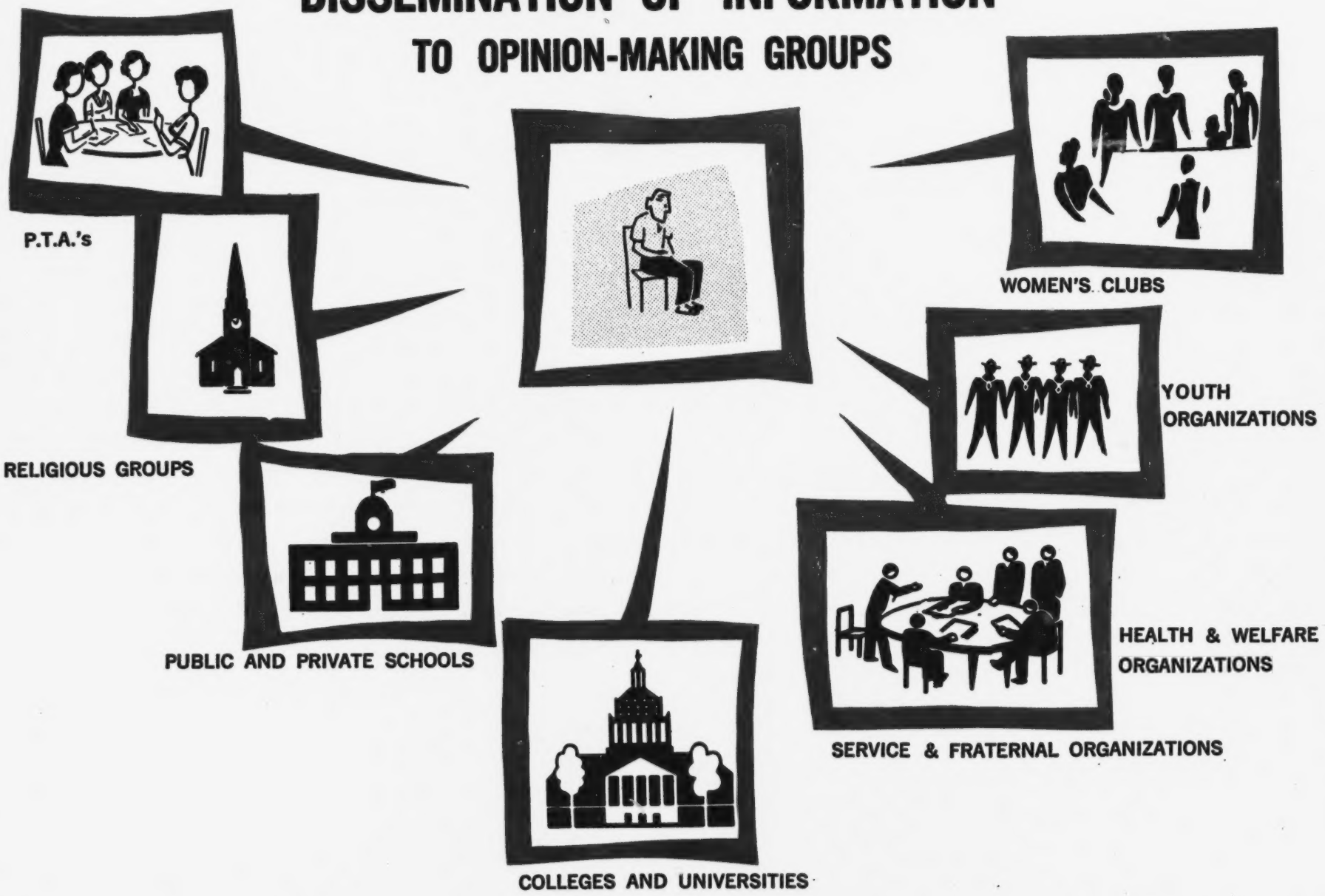
PRODUCTION OF TRAINING FILMS

Public Awareness

Organizations which affect public opinion should know more about the present status and potential of work with the retarded. These organizations usually function at the local level. Their increased awareness will help get support and improved programs and services for the retarded in local communities.

DISSEMINATION OF INFORMATION

TO OPINION-MAKING GROUPS



Coordination of Services

Responsibility must be designated by the Federal, State, and local authorities for the planning, development, and administration of services to the mentally retarded. All services need to be coordinated to provide comprehensive, continuous and improved care, and to insure community-centered rather than isolated services. Coordination of services, in addition to designation of responsibility, should improve research, care, treatment, training, education, rehabilitation, counseling, recruiting, employment service, placement and financing of programs for mentally retarded persons.

IMPROVED COORDINATION OF SERVICES

AT FEDERAL, STATE AND LOCAL LEVELS

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